MOST STATES REJECT MEHPA PAGE 5

Profits, Patents, & Seniors PAGE 10

Health Care News

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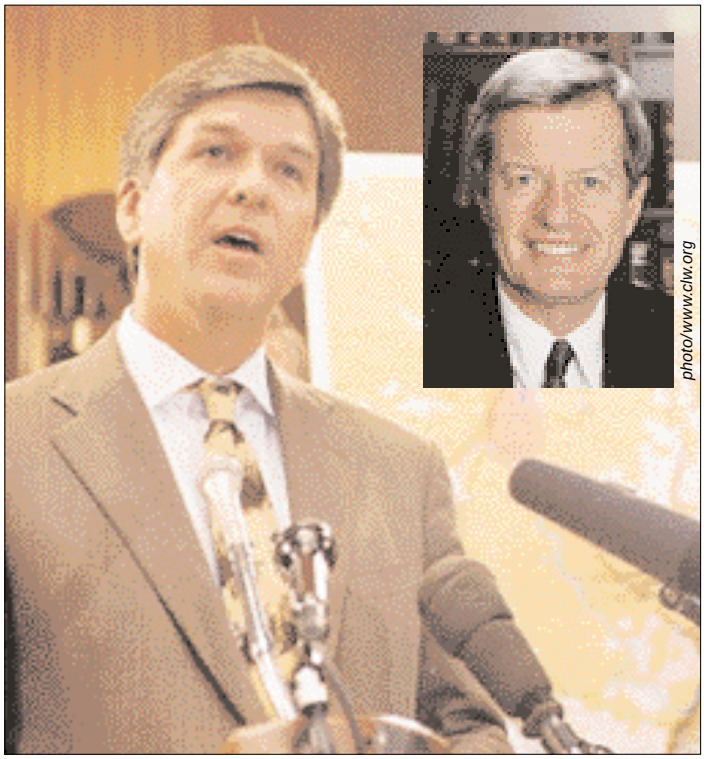
Congress OKs $100 Million for High-Risk Pools



photo/www.clw.org

Senators Gordon Smith (R-Utah) and Max Baucus (D-Montana, inset) attached to the Trade Adjustment Assistance Act legislation that authorizes the federal government to allocate $100 million for state high-risk pools. *photo/www.senate.gov*

BY CONRAD F. MEIER

The Trade Adjustment Assistance Act (TAAA), passed by the Senate on August 2 by a vote of 64-34, contains a little-known provision that could provide a big boost to market-based health care financing. The measure was signed by President George W. Bush on August 6.

Significant health care reform legislation is buried deep in TAAA, its presence mostly ignored by the mainstream media. Senators Max Baucus (D-Montana) and Gordon Smith (R-Oregon) are credited with getting the enabling legislation attached to the trade bill.

High-Risk Pool Funding

The trade bill provides $100 million in federal funding to help subsidize the cost of state high-risk pools (HIPs), which provide health insurance for high-risk individuals otherwise unable to find insurance. The federal measure requires that states cap the premiums charged to pool participants at 150 percent of standard health insurance premium rates, thereby ensuring the insurance will remain affordable for those who require high-cost medical care.

Sally Albright, executive director of the Health Insurance Safety Net Coalition, told *Health Care News*, "30 states currently operate successful high-risk pools. With TAAA, up to $1 million in 'seed money' for each of the remaining 20 states, including the District of Columbia, will be made available to cover initial start-up expenses."

In addition to start-up funding, the trade measure allocates $40 million in 2003 and 2004 to help all state pools, new and existing, with ongoing operational overhead and claims. States who take advantage of the start-up funding need not apply for the 2003 and 2004 continuing funds, which will require that they meet certain qualifications.

States seeking additional funding for their pools may not charge pool participants more than 150 percent of premiums charged in a stan-

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The Myths of Medical Monopoly and Monopsony

BY JOHN R. GRAHAM

Two erroneous notions have long infected the debate about appropriate public policies for prescription drugs. The first is that patents protecting intellectual property grant monopoly power and keep prices higher than they otherwise would be. The second is that the government can prevent drug makers from gouging patients by forcing discounts through its purchasing power as a single buyer. This is monopsony, the mirror image of monopoly.

Defenders of government-controlled health care constantly tell us that health care is different: It cannot be sold like pizza or bicycles. So, let's use a health care product that the government never took over to analyze these fallacies. In the 1910s, my grandfather dropped out of high school because he could not read the blackboard, and his family could not afford to buy eyeglasses for him.

Competing for Eyes

The history of the availability of eyeglasses to the common man is one of patented innova-

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State Drug Price Controls Backfire

Pharmacies and generic drug makers drop Medicaid participation

BY CONRAD F. MEIER

Politicians in Washington, DC and state capitols across the country have claimed the remedy for high-priced prescription drugs is to be found in enacting price controls on medications sold to senior citizens.

But in several laboratories of democracy, state officials are finding the proposed cure worse than the disease.

Rebellion in Missouri

Missouri officials and advocacy groups for the elderly say large generic drug manufacturers are not participating in the state's prescription drug program. At an August news conference, AARP claimed some drug manufacturers have refused to participate in the Missouri SenioRx Program because it requires them to pay a 15 percent rebate on top of existing federal rebate charges.

While 1,400 pharmacies and 100 drug manufacturers take part in the Missouri program, AARP said major generic drug companies Geneva Pharmaceuticals of New Jersey and two Pittsburgh-based companies, Mylan Laboratories, Inc. and TEVA Pharmaceuticals USA, have refused to offer their products for sale in the state.

In a news release issued immediately after AARP suggested foul play, TEVA said it is will-

BACKFIRE continued on page 8

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Patent Protection Law at Risk

BY CONRAD F. MEIER

Failing to pass a prescription drug benefit for seniors in July, the Senate offered consumers legislation that encourages cheaper generic alternatives to brand-name drugs by passing the Greater Access to Affordable Pharmaceuticals Act (GAAP).

Principal sponsors of the GAAP legislation, Senators Charles E. Schumer (D-New York) and John McCain (R-Arizona), claim it would save consumers $60 billion over the next decade by reducing the number of legal disputes over patents on brand-name drugs.

Under the measure, brand-name pharmaceutical companies would no longer be granted an automatic, 30-month extension of patents set to expire. Instead, the drug companies would have to go to court to get the patents extended. According to industry sources, the patent protection for intellectual property, which includes life-enhancing medications, would be severely compromised.

The bill was supported by a coalition of corporate employers, labor unions, and state governors, Business for Affordable Medicine (BAM), a major force pressing for reform of the Hatch-Waxman Act, the ruling authority on patent protection.

Big employers and insurers, including Blue Cross Blue Shield, General Motors, and Caterpillar, also lobbied on behalf of the bill, as did groups such as AARP and the National Governors Association. All see the bill as a way to lower health costs.

A similar bill, sponsored by Reps. Jo Ann Emerson (R-Missouri) and Sherrod Brown (D-Ohio), has been introduced in the House, where it faces an uncertain future. Rep. Billy Tauzin (R-Louisiana) said he will seek action, but House Speaker Dennis Hastert (R-Illinois) made no mention of the bill when he blasted the Senate for failing to pass a prescription-drug benefit.

Hastert's spokesman, John Feehery, said "We're not going to even entertain the notion" of a generic drug bill until the Senate takes clearer action on a prescription drug benefit.

If the House passes its version of GAAP, the two measures would be reconciled in a conference committee before being submitted for the President's signature.

Bad Public Policy

Alan Holmer, president of the Pharmaceutical Research and Manufacturers of America (PhRMA), called the GAAP bills "an example of election-year politics trouncing good public policy."

The bills would make a variety of changes in the Hatch-Waxman Act aimed at closing loopholes critics say brand-name manufacturers have used to extend patents on certain drugs. The key change: limiting to one the number of 30-month patent extensions routinely granted to brand-name drug makers as their patents near an end.

Brand-name drug makers argue they need the longer monopoly periods assured by the Hatch-Waxman Act to recoup their investments in research and development. Cutting off R&D financing would significantly slow—and in some cases, halt altogether—efforts to bring innovative new drugs to market. Generic drug makers do not innovate new medications. They simply copy and manufacture brand-name medications already developed.

> **"Physicians see patent protection for new prescription drugs as vitally important ."**

Intellectual Property Issues

Although he did not dispute the possibility that reform is needed, Senator Orrin Hatch (R-Utah) told Congress the GAAP legislation goes too far without a compelling demonstration of alleged abuses. Hatch warned GAAP upsets the careful balance achieved in 1984 with the Bolar provision of Hatch-Waxman, which allows generic drug firms to start the FDA approval process even before a drug's original patent has expired.

Hatch's position has support from an important group of experts: physicians. In March and April 2002, Ayres, McHenry & Associates conducted a national survey of physicians regarding their views on intellectual property issues. The survey results indicate physicians see patent protection for new prescription drugs as vitally important to the continued development of new drugs. Among the survey's findings:

- Seventy-five percent of doctors say patent protection for new prescription drugs is very important to create the incentives to discover and develop new drugs.
- Sixty-seven percent of doctors say weakening patent protection will hurt research and innovation. They think it realistic to fear weakening patent protection will lead to less research on cures for rare diseases.
- Eighty-eight percent of physicians say the continuing development of new prescription drugs is very important to their patients.
- Eight out of ten doctors give brand name pharmaceutical companies credit for discovering and developing new prescription drugs leading to breakthrough cures.
- Two-thirds of doctors consider it realistic to fear weakening patent protection for new drugs will increase the price consumers have to pay for medications.

For more information…

WWW The Senate version of GAAP legislation is available at the Thomas Web site at **http://thomas.loc.gov/cgi-bin/bdquery/z?d107:s.00812:**. The House version can be found at **http://thomas.loc.gov/cgi-bin/bdquery/z?d107:HR01862:**.

More information on the Ayres, McHenry & Associates survey of physicians can be found at the firm's Web site at **http://www.ayresmchenry.com/.**

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The PULSE

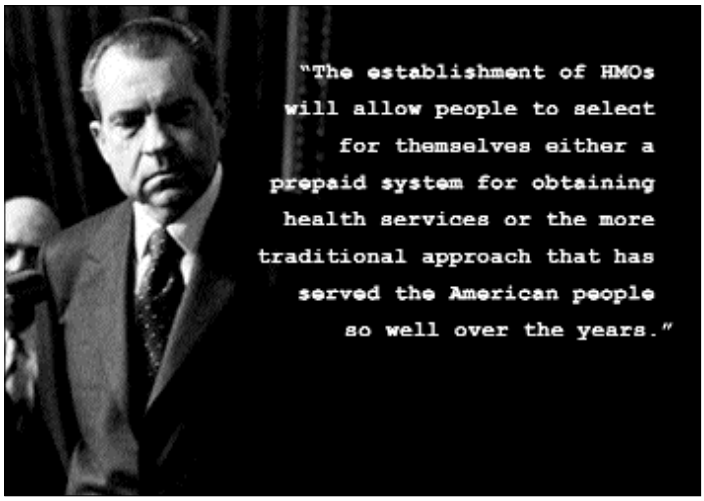
BY GREG SCANDLEN

FREE-MARKET HEALTH CARE REFORM IN THE NEWS

By Greg Scandlen

Scott Holleran publishes "The Pulse," a weekly email newsletter sort of like this one, on behalf of Americans for Free Choice in Medicine. His current edition includes a wonderful little "blast from the past" in the form of President Richard M. Nixon's statement on signing the federal HMO Act on December 29, 1973.

The statement is filled with ironies. For example, Nixon says, "The establishment of HMOs will allow people to select for themselves either a prepaid system for obtaining health services or the more traditional approach that has served the American people so well over the years." He goes on to say the Act will allow "both the provider and the consumer of health services to exercise the widest possible freedom of choice." He also calls on Congress to enact "an appropriate and responsive national health insurance act."


"The establishment of HMOs will allow people to select for themselves either a prepaid system for obtaining health services or the more traditional approach that has served the American people so well over the years."

To find out more about AFCM or to sign up for its "The Pulse" newsletter, go to http://www.acfm.org.

Source: http://www.nixonlibrary.org/Research_Center/1973_pdf_files\1973_0376.pdf

Survey: Texans Want Single Payer (?)

A new survey conducted by the University of Houston concludes a majority of Texans "favor a publicly funded national health care plan in which all Americans would receive their insurance from a single government source," according to the *Houston Chronicle*.

The article says 52 percent of Texans support such a plan, while 43 percent oppose it. Five percent did not answer the question. The article doesn't say how the question was worded, but it concludes the high level of non-insurance among Hispanic Texans is a major contributor to the survey findings. Sixty-four percent of Hispanics favored the idea, and only 57 percent of Hispanics are covered by insurance.

The story also says, "a majority of Texans think government politics has a negative effect on health care." According to the article, majorities of Texans surveyed favor "requiring businesses to offer private insurance for their employees; income tax deductions, tax credits, or financial assistance to help uninsured Americans purchase private insurance; expanding programs like Medicaid and CHIP; and expanding neighborhood clinics."

It sounds like a majority favors doing something ... anything ... to reduce the numbers of uninsured. They don't seem to be too fussy about what it is.

Source: The Houston Chronicle *is one of the more expensive daily archives. The story ran on July 14, 2002; you can find it at* http://www.chron.com/archives. *You might also want to search the University of Houston for the source material.*

New Canadian Survey on Waiting Times

Those Texans may want to reconsider the single payer idea.

A recent survey of 14,000 Canadians by Statistics Canada finds that, "Almost one in five Canadians who accessed health care for themselves or a family member in 2001 encountered some form of difficulty...."

The survey offers separate results for "first contact services" and "specialized services." About 94 percent of the population used first contact services, of which 18 percent (4.3 million people) had problems, with "long waits" and "problems contacting a health care provider" topping the list.

Of the 6.1 million people who needed specialized services, 23 percent had difficulty, with long waits being the biggest. Of those who needed non-emergency surgery, 40 percent waited less than a month (60 percent waited more), and of those who needed diagnostic tests, 55 percent waited less than a month (45 percent waited a month or more). Five percent waited six months or more for diagnostic tests, and 10 percent waited six months or more for non-emergency surgery.

Nine hundred thousand people said the waiting times "affected their lives," with 59 percent saying the wait induced "worry, anxiety or stress" and 37 percent saying they experienced pain.

Source: http://www.statcan.ca/Daily/English/020715/d020715a.htm

Maine: MSAs, Tax Credits Better than Single Payer

An editorial in the *Portland* (Maine) *Press-Herald* contends new entitlement programs—like the prescription drug benefit Congress is considering for Medicare and the single payer push before the Maine legislature—risk runaway costs and denied access to needed care.

Far better, says M.D. Harmon, to adopt a program like what The Heritage Foundation has long promoted with tax credits, risk pools, and FEHBP-type choice of plans. He likes MSAs as part of the mix.

Harmon also cites an article in the *Wall Street Journal* by CAHI's Merrill Matthews, who wrote about the Canadians who took a bus to Maine in search of better health care because what they needed wasn't available back home. "We can do better than this," writes Harmon. "But as the current debate in Maine and Washington shows, we can also do worse. Sadly, it looks like that's the direction we're headed."

Source: http://www.pressherald.com/viewpoints/harmon/020715harmon.shtml

Rhode Island Town to Offer MSAs to Residents

Down the coast, in Scituate, Rhode Island, the town is developing an MSA plan that will be available to all of the town's 10,000 residents, according to AMNews. The effort has been led by long-time health activist and family physician, Dr. Michael Fine.

In addition to an MSA/high-deductible health plan, participants would pay $200/year to support a "population-based primary care practice," which would actively service plan members (sounds a tad like "concierge medicine," doesn't it?).

The town council began looking for answers two years ago when the Harvard Pilgrim health plan left Rhode Island, leaving the Blues and UnitedHealthcare the only remaining carriers. The plan will start by being offered to municipal employees in 2003. The state legislature has enacted a $200 tax credit for all participants.

Source: http://www.ama-assn.org/scipubs/amnews/pick_02/bil20722.htm

Herzlinger: Time for Employer Risk Adjustments

While we're in New England, the *Boston Globe* ran a story by Charles Stein that is mostly an interview with Regina Herzlinger of the Harvard Business School, prompted by an article she wrote for the *Harvard Business Review*.

Stein sums up Dr. Herzlinger's views by saying, "Health care needs to work like other markets. ... We need to put the dollars and the decision-making power into the hands of the people who actually use the service. ... The result will be more choices, happier consumers, and moderating prices."

Stein says the argument isn't new, but, "for the first time, the world seems to be paying attention. Some of America's biggest companies and biggest insurers have embraced the concept of consumer-driven health care."

Herzlinger wants employers to go further than they have, however, to use "risk-adjusted policies." Stein gets an alternative point of view from Richard Kronick, a health policy specialist at the University of California at San Diego. Kronick is quoted as saying, "It's a fantasy." Markets only work when there is good information available, and in health care there isn't. Kronick concedes, however, that "right now these consumer policies seem to be the only thing left on the menu."

Source: The Globe *charges to access articles. The article ran on July 9, 2002. To find it go to* http://www.boston.com/globe/#search

"Unleashing the Tremendous Power" in Milwaukee

The *Milwaukee Business Journal* reports efforts by Richard Blomquist, former CEO of Associates for Health Care, a PPO, who is now working on a health plan design to enhance consumerism.

"The key to controlling health care costs is unleashing the tremendous power of consumers," he is quoted as saying. His plan design is based on publishing fee schedules for hospital and physician services.

Employees can compare those schedules to actual provider charges and shop accordingly. The article says, "The concept of attaching a price to a service has been absent on health care." It adds the plan design can be used with an MSA or as a stand-alone product.

Source: http://milwaukee.bizjournals.com/milwaukee/stories/2002/07/15/story4.html

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis in Dallas, Texas and assistant editor for Health Care News. *To sign up for his free weekly e-newsletter,* Scandlen's Health Policy Comments, *log on to* http://www.ncpa.org/sub. *Email Scandlen at* GMScan@aol.com.

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MEPHA Update: Most States Reject Law

BY CONRAD F. MEIER

A year ago this month, anthrax attacks sent shock waves from coast-to-coast and border-to-border as state health care officials tried to cope with potential bioterrorism and other public health emergencies following the September 11 terrorist attacks.

The Model Emergency Health Powers Act (MEHPA) was developed for the federal Centers for Disease Control and Prevention (CDC) and provided to state legislatures for adoption. In states where it has been adopted, MEHPA gives local authorities the power and the right to enforce quarantines, vaccinate people, ration medical supplies, confiscate food and fuel, and seize and destroy private property without compensation—all in the name of a public-health emergency. (See "Bioterror Act Creates Its Own Terror," *Health Care News*, May 2002.)

To date, only seven states—Arizona, Florida, Georgia, Maine, Maryland, Minnesota, and New Hampshire—and the District of Columbia have passed portions of MEHPA. No state has passed all, or even nearly all, of the model MEHPA legislation.

A dozen states—California, Connecticut, Idaho, Illinois, Kansas, Kentucky, Mississippi, Nebraska, Oklahoma, Washington, Wisconsin, and Wyoming—have affirmatively rejected or shelved MEPHA, while four others—Louisiana, South Dakota, Utah, and Vermont—effectively rejected the measure by passing an alternative bill.

Emergency health power laws are needed, federal officials say, because they give authorities the guidance and legal ability to make quick decisions in a public health emergency involving contagious or deadly pathogens. Most state health emergency laws haven't been updated since polio tore through the population a half-century ago.

"A broad coalition of opponents, including civil libertarians, assorted political parties, and conservative physicians, maintains the proposed law would violate individual rights and give government officials too much power."

"We have not used emergency powers in probably 50 years," says Gene Matthews, a lawyer for the U.S. Department of Health and Human Services. "This is something we need to attend to."

A Top-Down, Draconian Move

Veronique de Rugy, policy analyst at the Cato Institute, warns, however, "[MEPHA] is a top-down plan [and] a draconian move orchestrated by the lobbyists that represent the public health establishment. Among other bad things, it grants governors the authority to declare a state of emergency to deal with the threat of bio-terrorism in a harsh way.

"Because terms such as epidemic or infectious diseases are poorly defined," de Rugy continues, "the plan would give a bureaucrat the ability to declare a state of emergency when it pleases him (flu, gastroenteritis, AIDS ...), destroy property, and incarcerate people."

"The measure," says de Rugy, "also calls for information-exchange among doctors, pharmacists, and health organizations to place the population under surveillance between outbreaks. This would violate the doctor-patient privilege and one's right to privacy. Unfortunately, this scheme is not the first attempt by health authorities to deprive individuals of their privacy. It seems that parts of the plan have been sitting on the administration's shelves waiting for the right opportunity. The anthrax scare provided it."

Support Dwindles

A broad coalition of opponents, including civil libertarians, assorted political parties, and conservative physicians, maintains the proposed law would violate individual rights and give government officials too much power. The measure gives governors and state health officials nearly unchecked authority to coerce people into undergoing medical treatment, accepting quarantine or confinement, and unnecessarily disclosing their personal medical records.

"[O]nly seven states ... and the District of Columbia have passed portions of MEHPA. No state has passed all, or even nearly all, of the model MEHPA legislation. A dozen states ... have affirmatively rejected or shelved MEPHA, while four others ... effectively rejected the measure by passing an alternative bill."

The law "puts the lives of an entire state in the hands of one person who may or may not rise to the occasion," says Jonathan Turley, a law professor at George Washington University. "A state may be cursed with some dimwit."

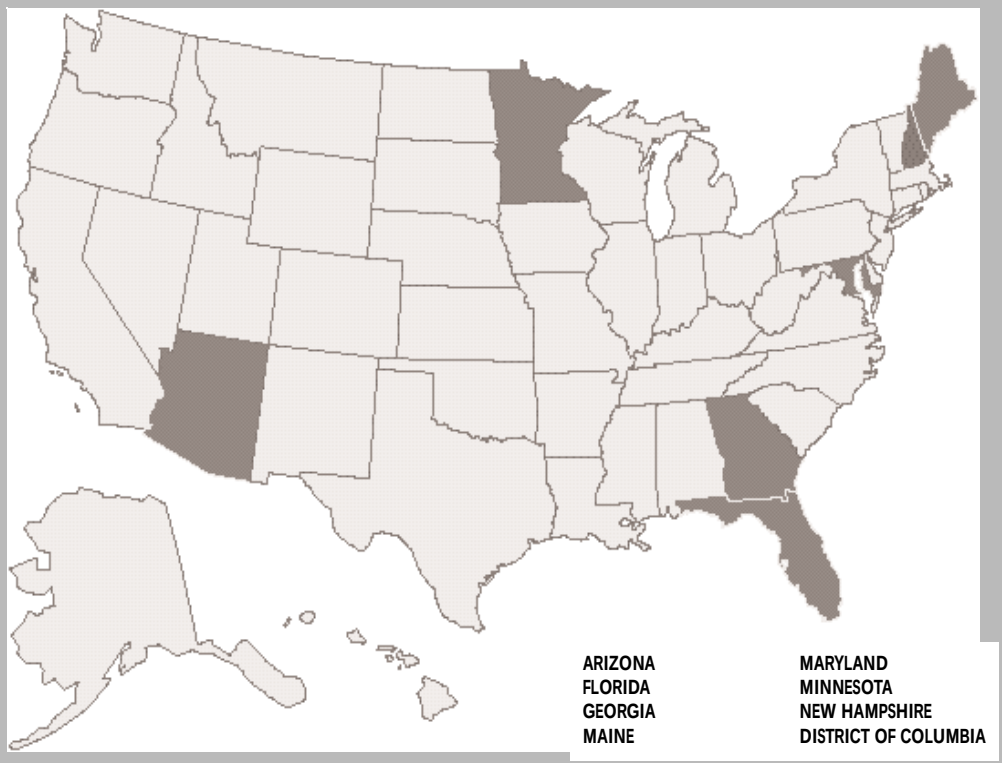
The act "goes far beyond bioterrorism," says Andrew Schlafly of the Association of American Physicians and Surgeons (AAPS). "Un-elected state officials can force treatment or vaccination of citizens against the advice of their doctors."

In California, efforts to pass the law were shot down last April. Dismayed his measure was rejected, Republican Assemblyman Keith Richman, the bill's sponsor and the legislature's only physician, says lawmakers are "already suffering from disaster amnesia. They have their heads stuck in the sand."

James Hodge of the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, which drafted the model law circulated among the states, attempted to defend the measure. "It would be used only in extreme cases," he told *USA Today*, which reported Hodge is "encouraged that so many states have adopted all or parts of the law."

The American Legislative Exchange Council (ALEC), a membership organization enrolling some 2,400 state legislators dedicated to free markets and individual freedom, has been tracking MEPHA's success—or lack thereof—in state legislatures across the country. Sandy Liddy Bourne, who oversees the issue for ALEC, stated in a news release, "We're talking about limiting firearms and property, taking clothing and livestock. This is not about protecting the public health."

These seven states plus DC have adopted parts of MEHPA legislation



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Colorado Health Insurance Market Evaporating

BY SPENCER SWALM, JD, REBC

Colorado's small group health insurance market displays all the symptoms of a patient in dire distress. While premiums and the ranks of the uninsured soar, the number of carriers plummets.

The legislature, retired for the year, has done little to stabilize the patient. The question hanging in the air with the urgency of an unanswered "code red" alarm is, "What can be done to resuscitate Colorado's small group market?"

Mandate Madness

The ills of that market are all too familiar. Rate hikes of 40 to 50 percent are commonplace, causing 85,000 Coloradoans to lose small group coverage last year. Many legitimate carriers have left the state. Arising in their place are scam artists that collect premiums and then fail to pay claims.

Changing this gloomy prognosis will be politically challenging. Nonetheless, the undeniable severity of the crisis may finally provide an opening to get something done. If so, a solution may well revolve around two key issues: suppressing the impact of mandated guaranteed-issue and promoting consumer-driven health care.

Much market disruption occurs when guaranteed-issue laws are imposed and when people who know they need insurance successfully obtain it after the fact. In other words, a homeowner is happy if he can persuade an insurance company to sell him a policy while his house is burning. Obviously, in the absence of fraud, he will rarely succeed. This is a good thing, not only for the profits of the insurance company, but also for homeowners who play by the rules and buy insurance before they know they need it.

For a variety of reasons, however, politicians have decided health insurance carriers must sell comprehensive policies to small companies (1-50 employees), and carriers must charge the same price to all comers, regardless of health conditions.

"[A] solution may well revolve around two key issues: suppressing the impact of mandated guaranteed-issue and promoting consumer-driven health care."

In the larger small groups, the law of averages works in favor of insurance companies: Only a few employees are seriously ill at any given time. A 1999 University of Northern Colorado study showed average monthly claims in groups from 5 to 50 people ranged from about $90 to $110.

Unfortunately, a different law is at work in smaller groups. The average monthly claim for groups of just 2 to 4 persons was about $170; for a group of one, it was nearly $220. When the rules say you can wait to buy insurance until your house is on fire, why be a sucker and pay for it before then? Economists call this a "moral hazard," and its predictable result is ruinous losses for insurance companies and staggering rate increases for the rest of us.

Reducing the negative impacts of guaranteed-issue won't be painless. It will probably involve making it both more difficult and more expensive for small groups to buy insurance after they already know they need it. Nonetheless, to preserve affordable health insurance for all Coloradoans, responsible action is imperative.

Market Forces

Consumer-driven health care means patients, not just insurance companies, have a direct financial stake in what health care costs. Without co-pays, patients neither know nor care what providers charge the insurance company. Low co-pays encourage a use-it-or-lose-it mentality: If you don't use the plan, you are "losing" your premiums.

To some degree, skyrocketing premiums are dragging consumers back into the health care financing equation. Increasingly, small employers are turning to PPO plans with high deductibles and co-insurance to hold down costs. When the patient is faced with paying 20 percent of the bill, what providers charge becomes a matter of real interest.

A crucial ingredient in the struggle to restrain exploding costs is to align the system so that patients and insurers have similar goals: getting the most bang for each health care buck.

Is there anything the legislature can do to encourage the move to consumer-driven health care? Yes: Make Colorado safe for Medical Savings Accounts (MSAs).

Derided as a toy of the "healthy and wealthy" when HMOs were cheap, MSAs are now widely viewed by experts as being an important part of the solution. MSAs combine high-deductible insurance policies with tax-advantaged saving accounts to pay medical bills not covered by the policy. Giving carriers greater latitude to set premiums based on risk is essential if Colorado is to enjoy a viable group MSA market.

"Rate hikes of 40 to 50 percent are commonplace, causing 85,000 Coloradoans to lose small group coverage last year."

Breathing life back into Colorado's comatose small group health market will not be easy, but it is possible. Limiting mandates like guaranteed-issue and promoting consumer-driven health care options should be parts of the cure.

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MYTHS continued from page 1

tion. In 1804, the meniscus lens was patented. Patents for innovations to eyeglasses were still being granted in the twentieth century. The first corneal contact lens was patented after World War II, leading to countless papers and several new journals dedicated to the new technology.

Between 1910 and 1997, the number of optometrists in the United States multiplied more than eleven times, versus a doubling of the general population. The real price of high-quality glasses was dropping, making them widely available. Advertising supported competition in selling eyeglasses: a lesson for those who would prohibit it for prescription drugs. In 1963, prices of eyeglasses in American states that restricted their advertising were 25 percent higher than in states that allowed it.

For more recent times, data series extracted from Statistics Canada's CANSIM II database show that, between 1985 and 2001, the price of eye care in Canada dropped 23 percent relative to the Consumer Price Index. In 1998, Canadian households' average expenditure on prescription eyeglasses was $113. In Canada and the United States, innovation and competition quickly brought eyeglasses to everyone.

Great Britain did it differently. The National Health Service (NHS) provided standard, wire framed, widely derided "granny glasses" to citizens. The generally ridiculed granny glasses show how bad the government is at buying health care goods for the individual. First, the government's agents are not spending their own money. Therefore, they are not motivated to spend it as carefully as the individual is.

Second, there is "information asymmetry." Even if it is acting in good faith, the government is incapable of knowing what value different individuals put on different aspects of health care. So the committee in charge of buying eyeglasses simply chooses a single product that it finds easiest to manage.

In 1986, the NHS wisely got out of this business by switching to vouchers that people could use to buy glasses of their choice.

Which Shall We Subsidize?

A current example of misguided monopsony is the Reference Drug Program of British Columbia's Pharmacare, whereby a committee bundles drugs into classes that it believes are therapeutically equivalent. The committee decides which drugs are fully subsidized and which are not.

Pharmacare's managers invested more than $2 million from various agencies for research into the effects of the Reference Drug Program. The results published so far are unable to say what the effect of the program has been.

The team researching ACE inhibitors (used for hypertension and congestive heart failure) concluded: "Further research is needed on the overall health and economic effects of such policies." Moreover, they wrote, "We could not directly measure all changes in the health status of patients but only changes that led to contact with health care professionals."

Similarly, the team researching reference pricing of nitrates (used for angina) concluded: "Additional research into the 'downstream' consequences of reference-based pricing is therefore necessary to determine the overall effects of the policy."

Only five drug classes are reference priced, but the committee must approve every subsidized drug. Pharmacare accounts for 53 percent of the province's prescription drug expenditures. A policy that takes over half of patients' pharmaceutical budgets and commits it entirely to drugs selected by the government is bound to lead to "granny glasses" style medicine.

The cost of spectacles and contact lenses has fallen dramatically, and quality and choice increased in the last century ... not because of the state's monopsony, but because manufacturers had to compete for every single customer. If governments got out of the prescription drug business, the results would be the same.

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ing to participate in the Missouri program, but only at the federal rebate level. A 1990 federal law requires drug companies to offer rebates to states in exchange for reimbursement from Medicaid.

A TEVA spokesperson said, "The imposition of larger rebates on generic drugs is likely to have the perverse effect of reducing competition as generic companies discontinue products that cannot be produced and sold in a way that makes economic sense." TEVA participates in 50 state Medicaid programs and 41 supplemental programs like Missouri SenioRx.

"[U]p to 25 percent of the [Washington] state's 1,100 pharmacies will stop participating in the state's Medicaid program as a result of the [reimbursement rate] cuts."

The revised Missouri prescription drug benefit became available July 1 for more than 26,000 low-income senior citizens. The program pays 60 percent of the prescription costs for seniors after they meet an annual deductible. It replaces a state income tax credit, worth up to $200 annually, that was intended to help offset seniors' medicine costs.

Democratic Governor Bob Holden expressed concern about the decision of generic drug manufacturers to pull out of the Missouri program. "I was extremely disappointed to learn that some generic pharmaceutical manufacturers have decided not to participate in the program," Holden said in a news release. "I encourage these manufacturers to reconsider their decision not to participate in the Missouri SenioRx Program."

The General Assembly authorized the new benefit during a special session in September 2001. The initial enrollment period ended May 30, 2002, but seniors who turn 65 during the next year can still apply.

Pharmacies Leave Massachusetts Medicaid

Following CVS Corp.'s lead, drugstore chains Brooks Pharmacy and Walgreen Co., as well as some independent operators, have announced they will no longer participate in Massachusetts' Medicaid prescription drug program.

A July 29 move by Acting Governor Jane Swift (R) led to the pharmacies' decision. As part of the state's budget revision, Swift announced she would reduce Medicaid payments to pharmacies, from 10 percent above the wholesale cost to 2 percent below wholesale.

Department of Health officials report the pharmacy payment cuts are expected to save about $60 million a year. According to research conducted by the *Boston Herald*, the three chains, which run 555 of the state's 1,014 pharmacies, fill 60 percent of prescriptions for Medicaid beneficiaries. CVS alone fills about one-third of those prescriptions.

Robert Gittens, Massachusetts' secretary of health and human services, has asked CVS to continue to serve beneficiaries for at least 60 days, during which time lawmakers intend to hold hearings on the market disruption created by mandates and rebates.

CVS spokesperson Todd Andrews told the *Boston Globe* the chain would consider returning to the program only if Linda Ruthardt, the state commissioner of health care finance and policy, agrees to increase the reimbursement rate "down the road."

Any rate change, however, would have to be approved by the state legislature, which has concluded its formal session for the year. State Senate Ways and Means Chair Mark Montigny (D) said lawmakers would need more information before making such a change, adding, "If there is a feeling that we have been irresponsible, then [the pharmacies should] tell us in a public hearing."

Discontent in Washington State

To offset a "ballooning state Medicaid drug budget," Evergreen State lawmakers are imposing pharmacy reimbursement cuts, including a 3 percent reduction in payment rates for name-brand drugs and a massive 44 percent cut for generic drugs. A report issued by the inspector general of the U.S. Department of Health and Human Services concluded states have been overpaying for medications for Medicaid beneficiaries.

The payment rate cuts will affect the nearly 500,000 beneficiaries enrolled in the traditional Medicaid plan offered by Washington State. The 400,000 beneficiaries enrolled in the state's Medicaid managed-care plan, Healthy Options, will not be affected.

"Following CVS Corp.'s lead, drugstore chains Brooks Pharmacy and Walgreen Co. ... have announced they will no longer participate in Massachusetts' Medicaid prescription drug program."

According to Rod Shafer, CEO of the Washington State Pharmacy Association, up to 25 percent of the state's 1,100 pharmacies will stop participating in the state's Medicaid program as a result of the cuts. Some large pharmacy chains, including Bartell Drug, Safeway, Fred Meyer, and Rite Aid, are considering but have not yet decided whether to discontinue their participation in the program.

Many independent and smaller chain pharmacies have said the cuts in reimbursement rates will make it financially impossible for them to remain as Medicaid participants.

Why Price Controls Don't Work

State efforts to rein in health care spending by imposing price controls on pharmaceutical manufacturers are not the first time price controls have been suggested in the health care reform debate. In 1993, the Clinton administration promised the business community its reforms would rein in the cost of employee health insurance and reduce waste and unnecessary administrative expenses. But as details of the Clinton plan became public, it became clear the plan would *increase*, not decrease, the financial burden on business. Recognizing that it risked losing whatever business support it had for its plan, the administration said it would consider placing temporary price controls on health care providers and insurers. It would have been a tremendously costly mistake.

Price controls, C. Jackson Grayson, Jr. wrote at the time, "have not worked in 40 centuries. They will not work now." Grayson, who was chairman of the Nixon Price Commission between 1971 and 1973, went on to present seven reasons why price controls wouldn't work in health care. They still make a compelling case against price controls.

1. "Getting into controls is a lot easier than getting out of them." Once in place, price controls make "fixing" the original problem even more difficult. Politicians soon fear that lifting the controls will result in a price explosion . . . which it invariably does.

2. "No matter how clever the price control designers, they cannot prevent distortions." Cost-shifting, unbundling services, black markets, shortages . . . these and more resulted from price controls in the '70s and are likely to be repeated if price controls are tried again.

3. "Quality does not improve with controls." What we *want* is greater efficiency and higher quality for the dollars we spend on health care. What price controls *deliver* is temporarily lower prices at a steep cost in lost quality.

4. "Cost controls actually increase costs." The cost of enforcing and complying with price controls would be massive. Doctors, hospital administrators, and insurance companies are already buried with paperwork; price controls would double or triple that burden.

5. "Controls breed more controls." The Nixon price controls started with 3-1/2 pages of regulations and ended with 1,534. Every decision on how the price controls applied to one product or service led to the need for new decisions on other goods and services . . . *ad infinitum*.

6. "Voluntary becomes mandatory." The record of voluntary price controls is very poor, and they are usually only a prelude to mandatory controls. Recommending voluntary controls, therefore, is not a prudent compromise or accommodation; it is a definite step toward mandatory price controls and all the costs that will follow.

7. "Global budgets don't work." There is no way to enforce global budgets because there is no political will to counter the interest groups that support higher spending. Spending doesn't stop when a budget ceiling is reached.

Source: C. Jackson Grayson, Jr., "Experience Talks: Shun Price Controls," *The Wall Street Journal*, March 29, 1993.

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Why Do Public Health Advocates Lie About the Risks of Smoking?

BY JOSEPH L. BAST

At the Northwestern train station in downtown Chicago, commuters are met with a billboard that reads: "Odds of dying in a car crash: 6,200 - 1; dying from smoking: 3 - 1."

The ad, paid for by the Illinois and Chicago departments of public health, is obviously meant to encourage smokers to quit. But is it accurate?

Apples and Oranges

The billboard's message is fraudulent two ways. First, it compares the risk of driving a car for one year with the risk of smoking for a lifetime, an apples and oranges comparison. The "odds of dying in a car crash" were apparently derived by dividing the total population of the U.S. by the annual number of vehicular deaths in the U.S.: about 280 million divided by 45,000. Given a life span of 75 years, the *lifetime* odds of dying from a car accident are really about 90 to 1, not 6,200 to 1.

Second, the billboard exaggerates the odds a smoker faces of dying from smoking. The actual odds of dying from smoking before the age of 75 are about 12 to 1. Describing how this estimate is derived simultaneously rebuts much higher estimates popular in the public health community.

The Surgeon General, using statistical models, estimates a total mortality risk from smoking between .18 and .36. The billboard's claim of "3 - 1," or .33, is at the high end of this range.

But the basis for these numbers has come under heavy fire from experts, such as Robert Levy, an adjunct law professor at Georgetown University, and Rosalind Marimont, a mathematician and scientist who worked for the National Institutes of Health for 16 years before retiring.

Lies and Statistics

In a 1998 article titled "Lies, Damned Lies, and 400,000 Smoking-Related Deaths," Levy and Marimont show how removing diseases for which a link between smoking and mortality has been alleged but not proven cuts the hypothetical number of smoking-related fatalities in half.

Replacing an unrealistically low death rate for never-smokers with the real fatality rate cuts the number by another third.

Controlling for "confounding factors"—such as the fact that smokers tend to exercise less, drink more, and accept high-risk jobs—reduces it by about half again. Instead of 400,000 smoking-related deaths a year, Levy and Marimont estimate the number to be around 100,000.

This would place the lifetime odds of dying from smoking at 6 to 1 (45 million smokers divided by 100,000 deaths per year x 75 years), rather than 3 to 1. However, about half (45 percent) of all smoking-related deaths occur at age 75 or higher. These can be called "premature"

"The odds of a life-long smoker dying prematurely of a smoking-related disease, then, are about 12 to 1."

only by stretching common usage of the word. The odds of a life-long smoker dying prematurely of a smoking-related disease, then, are about 12 to 1.

A billboard that reads "Odds of dying in a car crash: 90 - 1; dying from smoking, 12 - 1," would more accurately convey the truth than the current model, but might be less likely to capture our attention. Is it okay for health officials to lie to get our attention?

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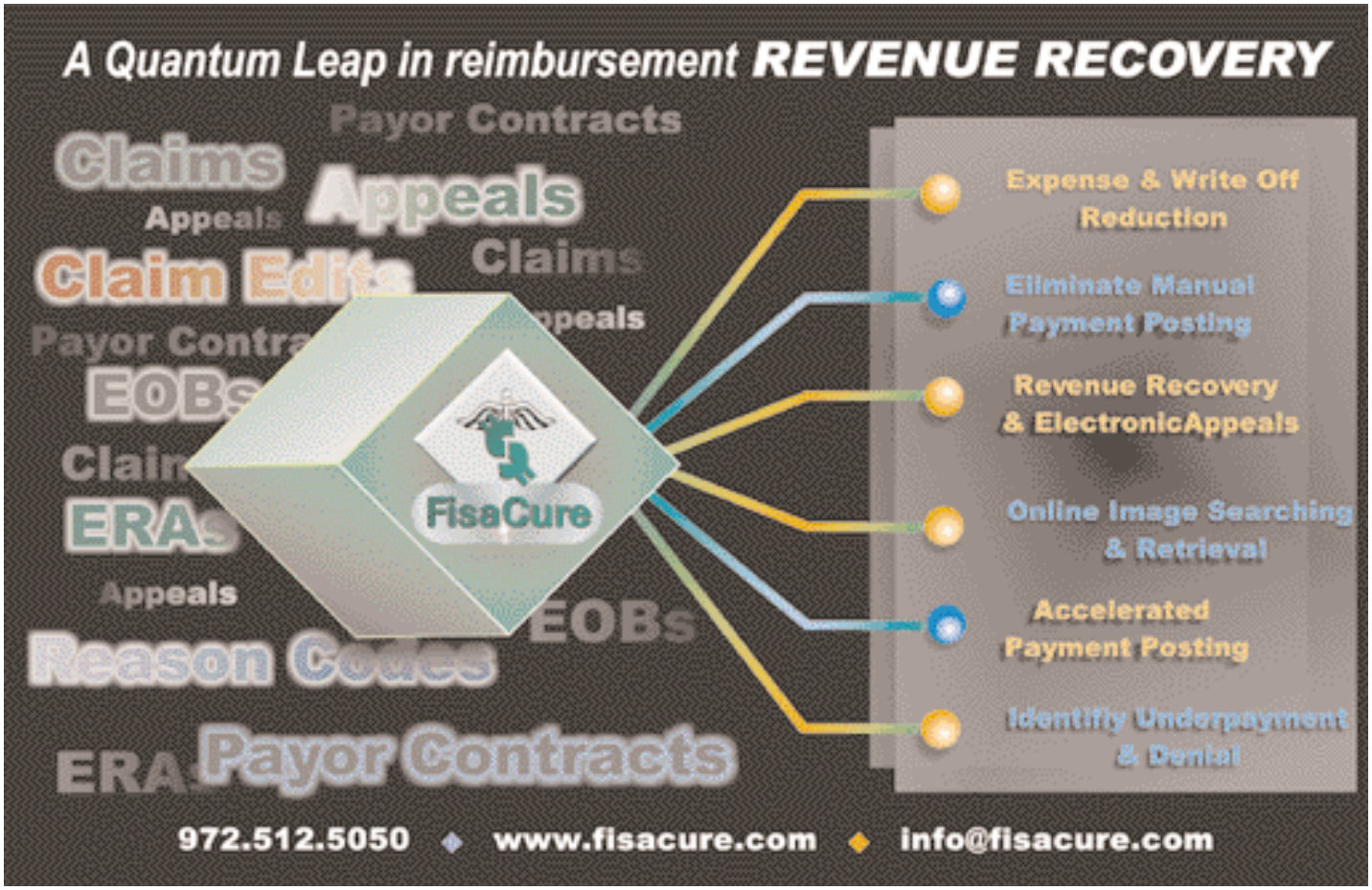

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Profits, Patents, and Seniors

A guide for policymakers

William Novelli, CEO of the American Association of Retired Persons (AARP), announced at a May 29 news conference in Washington, DC that AARP is joining three lawsuits against prescription drug manufacturers. The litigation threatens to keep the nation's drug companies focused on the courtroom, not the laboratory, to the detriment of seniors and all Americans. *photo by Alex Wong/Getty Images*

BY HERBERT W. STUPP

The U.S. House of Representatives passed Medicare prescription drug benefit legislation, only to have it defeated in the Senate. AARP—the nation's largest organization of senior citizens—issued a statement endorsing the passage of a drug benefit, but demanding higher spending and more generous coverage. AARP wants all of its members—all seniors, in fact—to enjoy good health and access to prescription drugs.

Or does it?

Over the past two months, AARP has embarked on a course of action that could undermine its own goals, announcing it will join several class-action lawsuits aimed at lowering prescription drug prices. AARP similarly announced it would join lawsuits to challenge drug companies' marketing of brand-name pharmaceuticals in order to make "generic drugs more readily available to consumers." An AARP board member, Dr. Beatrice Braun, was quoted as saying the organization would seek to "stop the abuse of drug patent laws."

In my eight years as New York City's commissioner on aging, I collaborated with and came to respect local AARP staff and volunteers. Unfortunately, the national AARP's litigation campaign against prescription drug advertising and the patent rights of research-based pharmaceutical companies is a stiff dose of snake oil.

Intellectual Property Rights

During my tenure, I visited with many of New York City's 1.3 million senior citizens. Especially before September 11, sentiment ran high for Medicare prescription drug coverage. High drug costs, and what to do about them, came up at forums around the city. I occasionally asked seniors and their advocates this question: "Suppose the research scientist who cured cancer or Alzheimer's became a wealthy person. Does anyone have a problem with that?" No one ever did.

Yet some people who supported financial rewards for the individual who develops a remedy, want that person's employer restrained or even punished. Imagine the world today if the minds that developed Cipro, Viagra, or Vioxx decided the incentives were too paltry for them to bother embarking on the typical 14-year, $800 million odyssey to steer a new drug around multiple regulatory roadblocks on to America's consumer market.

"[T]he national AARP's litigation campaign against prescription drug advertising and the patent rights of research-based pharmaceutical companies is a stiff dose of snake oil."

Prescription drug costs remain a legitimate and ongoing concern for millions of seniors. But is there a better way to solve these problems than asking: "Is there a lawyer in the house?" My experience suggests that there is, and that the following four principles should guide policymakers:

1. Immediate, targeted assistance for senior citizens lacking prescription drug coverage. Until prescription drug coverage is incorporated into Medicare, state governments and pharmaceutical companies can help address this issue.

If state governments cannot provide a widely available drug benefit, they should assist the neediest seniors—those least able to pay for prescriptions, and those with the gravest conditions. Pharmacists and their employees, religious institutions, senior citizen programs, and other organizations can help states identify these "at-risk" elders.

Pharmaceutical companies, which have received little media attention for their own "drug cards" and prescription savings plans, might assist state governments so that public and pri-

Congress Gets Hooked on Rx Drug Plans

BY GRACE-MARIE TURNER

Bidding wars over a Medicare prescription drug benefit are accelerating, with political leaders behaving as though they were in a high-stakes poker game with no tomorrow.

Earlier this year, President George W. Bush proposed spending $77 billion over 10 years for a drug benefit for low-income seniors. The latest offering from Senate Democrats could cost 13 times that: $1 trillion or more.

Providing a prescription drug benefit through Medicare clearly is important, especially for low-income seniors without insurance coverage. But creating a benefit that is prohibitively expensive for taxpayers and that would send pharmaceutical research into a tailspin clearly is reckless.

Nevertheless, many officeholders believe this could be the make-or-break domestic issue for the fall elections, and there appears to be no limit to the bidding.

Proposals Abound

The newest proposal by Senate Democrats would create a drug benefit for Medicare with a $25 monthly premium, no deductible, and fixed fees for medicines. Seniors would pay $10 for generics, $40 for brand names, and $60 for "non-preferred" drugs. After $4,000, the government would pay all drug costs.

The House Democrats' version would require seniors to pay a $25 monthly premium, a $100 deductible, and then 20 percent of drug costs up to $2,000, after which full catastrophic coverage would kick in. Both plans appear generous, but would quickly lead to heavy-handed, destructive, and ultimately unworkable price controls, with restrictions on access and huge new costs to taxpayers.

House Republicans have offered a more modest drug benefit bill, which would cost "only" $350 billion and incorporates needed Medicare reforms. But they are clearly at a disadvantage in this escalating bidding war. The GOP plan would ask seniors to pay $34 a month for coverage that pays 80 percent of drug costs from $251 to $1,000 and 50 percent of costs from $1,001 to $2,000. Catastrophic coverage would trigger at $4,500. The benefit would be dispensed by private, competing health plans.

On Second Thought ...

Anyone looking at the different proposals would say the Democrats' plans look best: They are easier to understand and appear a lot more generous. But the cost to taxpayers and future health care consumers from an open-ended entitlement would be enormous.

The federal government instantly would get involved in setting prices and restricting access to the newest drugs, policies that have seriously damaged pharmaceutical research and innovation in Europe.

For senior citizens worried about government controlling what's in their medicine chests, the word "nonpreferred" means politicians would decide which drugs will be available and which won't.

Few expect legislation to be signed into law this year. That is a good thing. Americans need time to grasp the extraordinarily important consequences of such a new entitlement. It is not simply one more Medicare benefit, as many would have voters believe.

Instead, it could well be a referendum on medical progress. Pharmaceuticals are software for the body—the latest medical technologies that extend life expectancy, improve the quality of life, and enhance doctors' abilities to treat and even cure disease.

Seniors are demanding a prescription drug benefit because they know these products represent the cutting-edge of today's medicine. Controls and access restrictions that would result from an overly generous drug entitlement are certain to dry up the investment capital needed to continue this

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vate efforts dovetail to enhance rather than duplicate coverage. (See "Stop Demonizing the Good Guys," *Health Care News*, November 2001.]

2. Continued pharmaceutical innovation.
No one benefits more from the development of new medicines than senior citizens. Older Americans have a particular interest in seeing the U.S. maintain the pace of biomedical innovation. This requires preserving incentives, including solid patent protection for drug companies that develop new medicines, and an avoidance of the kind of price controls that have done serious harm to Europe's once-healthy drug sector.

3. Faster regulatory approvals.
In recent years, the Food and Drug Administration (FDA) has significantly slowed its approvals of new medicines. That means patients are waiting for treatments that could save their lives, or greatly improve their quality of life. Congress can help accelerate the approval process by reauthorizing the Prescription Drug User Fee Act, which allows FDA to collect user fees from pharmaceutical companies seeking new drug approvals.

4. The First Amendment should apply to drug companies, too.
Patients should have access to abundant information on both brand-name and generic medicines. "Direct to Consumer (DTC)" advertising by brand-name companies should be as lawful in a free society as advertising by generic companies or advocacy groups.

According to the Kaiser Foundation, one in three adults has talked to a doctor in response to a drug ad. DTC advertising helps patients to actively participate in their own health care, increasing the likelihood they will take prescribed medicines correctly.

Elderly Americans are fortunate to live in a nation that leads the world in developing life-saving and longevity-enhancing drugs. AARP and its partners in litigation should find a more constructive way to help seniors than this misguided quest to punish the companies that are producing today's—and tomorrow's—cures. Keeping the drug companies focused on the laboratory, not the courtroom, is the right way to go.

Herbert W. Stupp was commissioner of the New York City Department for the Aging from 1994 to 2002, serving in the cabinet of Mayor Rudy Giuliani. This article was first published on July 9, 2002 by National Review Online.

progress, as already has happened in Europe.

Once the world's greatest medical innovator, excessive government interference in the European marketplace has crippled research. Governments have used their purchasing power to push down the prices of drugs. The end result is significantly less profit and, consequently, significantly less revenue available for research.

Between 1975 and 1994, the United States developed 45 percent of new major drugs. France produced only 3 percent, Germany, 7 percent, and Britain, 14 percent.

Because of price controls imposed by other countries, consumers in the United States pay a disproportionate share of research costs, often leading to higher prices. The solution is for other wealthy industrialized nations to pay their fair share for research ... not to cripple research here that holds the promise for cures for cancer, Alzheimer's disease, Parkinson's disease, and a host of other deadly and disabling illnesses.

Grace-Marie Turner is president of The Galen Institute, a nonprofit organization focusing on health care economics, and a contributing editor to Health Care News. *This commentary was distributed by Knight Ridder/Tribune Information Services.*

Senate Rejects Yet Another Rx Plan

BY CONRAD F. MEIER

A Medicare prescription drug benefit is all but dead for this year's Congressional session. The Senate defeated a scaled-back plan to help the nation's neediest seniors pay for their medicines. The measure failed July 31 on a 50-49 procedural vote, 11 short of the 60-vote supermajority required under Senate rules.

Advocates of competing proposals promised to continue their efforts. But with the Senate leaving for an August recess and Fall political campaigns looming, Democrats and Republicans alike are pointing fingers and taking the issue home to their districts.

The Senate action defeated a fourth and final proposal for a drug benefit, following similar votes earlier in July. Sponsored by Senators Bob Graham (D-Florida) and Gordon Smith (R-Oregon), the Medicare Outpatient Prescription Drug Act (S 2625) offered a 10-year, $400 billion plan backed by most Democrats. It would have covered drug costs for seniors whose income is less than twice the poverty rate—$17,720 for singles and $23,880 for couples. Seniors whose annual drug costs exceed $3,300, regardless of income, would also have qualified.

The Senate's failure to pass drug benefit legislation means senior citizens who rely on Medicare will receive no federal assistance for their prescribed medicines. The program does not cover drugs except those taken during a hospital stay.

While most senior citizens have prescription drug insurance through other sources, such as individual or employer-provided insurance policies, about one-third do not.

At Issue

Lawmakers were unable to find a compromise position that would bridge the wide ideological gap separating Republicans and Democrats, all of whom see the prescription drug benefit debate as one element of a much bigger issue: the future of Medicare.

Simply put, most Republicans insist any new benefits should be provided as subsidies to private HMO-type insurers. Most Democrats, by contrast, want any new benefits to be handled within the government-run Medicare system.

John Rother, policy director for AARP, the nation's largest senior-citizen interest group, expressed disappointment. "We're determined to make this not the end, but conventional wisdom says this was the best shot we had," he said.

The Republican-controlled House approved its own prescription drug bill in June on a near-party-line vote. The measure would provide subsidies to HMOs and other insurers to cover senior citizens.

How They Voted

50 Yes; 49 No; 1 Not Voting

Measure required a 60-vote supermajority, and thus failed

STATE	SENATORS	VOTE	STATE	SENATORS	VOTE
Alabama	Sessions (R) Shelby (R)	No No	Montana	Baucus (D) Burns (R)	Yes No
Alaska	Murkowski (R) Stevens (R)	No No	Nebraska	Hagel (R) Nelson (D)	No No
Arizona	Kyl (R) McCain (R)	No No	Nevada	Ensign (R) Reid (D)	No Yes
Arkansas	Hutchinson (R) Lincoln (D)	Yes Yes	New Hampshire	Gregg (R) Smith (R)	No No
California	Boxer (D) Feinstein (D)	Yes Yes	New Jersey	Corzine (D) Torricelli (D)	Yes Yes
Colorado	Allard (R) Campbell (R)	No No	New Mexico	Bingaman (D) Domenici (R)	Yes No
Connecticut	Dodd (D) Lieberman (D)	Yes Yes	New York	Clinton (D) Schumer (D)	Yes Yes
Delaware	Biden (D) Carper (D)	Yes Yes	North Carolina	Edwards (D) Helms (R)	Yes Not Voting
Florida	Graham (D) Nelson (D)	Yes Yes	North Dakota	Conrad (D) Dorgan (D)	Yes Yes
Georgia	Cleland (D) Miller (D)	Yes Yes	Ohio	DeWine (R) Voinovich (R)	No No
Hawaii	Akaka (D) Inouye (D)	Yes Yes	Oklahoma	Inhofe (R) Nickles (R)	No No
Idaho	Craig (R) Crapo (R)	No No	Oregon	Smith (R) Wyden (D)	Yes Yes
Illinois	Durbin (D) Fitzgerald (R)	Yes No	Pennsylvania	Santorum (R) Specter (R)	No Yes
Indiana	Bayh (D) Lugar (R)	Yes No	Rhode Island	Chafee (R) Reed (D)	No Yes
Iowa	Grassley (R) Harkin (D)	No No	South Carolina	Hollings (D) Thurmond (R)	No No
Kansas	Brownback (R) Roberts (R)	No No	South Dakota	Daschle (D) Johnson (D)	Yes Yes
Kentucky	Bunning (R) McConnell (R)	No No	Tennessee	Frist (R) Thompson (R)	No No
Louisiana	Breaux (D) Landrieu (D)	No Yes	Texas	Gramm (R) Hutchison (R)	No No
Maine	Collins (R) Snowe (R)	Yes No	Utah	Bennett (R) Hatch (R)	No No
Maryland	Mikulski (D) Sarbanes (D)	Yes Yes	Vermont	Jeffords (I) Leahy (D)	No Yes
Massachusetts	Kennedy (D) Kerry (D)	Yes Yes	Virginia	Allen (R) Warner (R)	No No
Michigan	Levin (D) Stabenow (D)	Yes Yes	Washington	Cantwell (D) Murray (D)	Yes Yes
Minnesota	Dayton (D) Wellstone (D)	Yes Yes	West Virginia	Byrd (D) Rockefeller (D)	Yes Yes
Mississippi	Cochran (R) Lott (R)	No No	Wisconsin	Feingold (D) Kohl (D)	No Yes
Missouri	Bond (R) Carnahan (D)	No Yes	Wyoming	Enzi (R) Thomas (R)	No No

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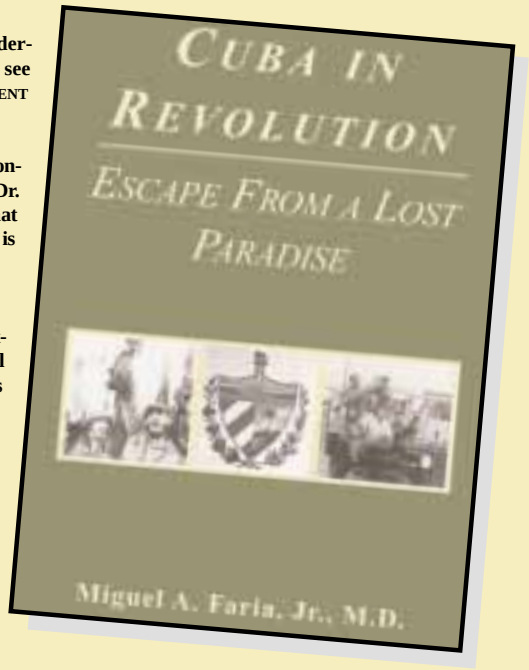
HERE'S WHAT THE PUNDITS ARE SAYING!

"*Cuba in Revolution—Escape From a Lost Paradise* is the key to understanding Cuba: From the rise of Castro to the Cuba we hope to see after Castro's fall...Get this book."—CHRISTOPHER RUDDY, PRESIDENT AND CEO, NEWSMAX MEDIA, INC.

"America's recent political history is marked by the gradual abandonment of freedom for the promise of government-provided security. Dr. Miguel Faria knows better than most the danger that lies down that path. I pray that enough people read his book...and learn...before it is too late!"
—NEAL BOORTZ, NATIONALLY-SYNDICATED RADIO TALK SHOW HOST

"Americans need to know more about how the Castro problem started and has remained a festering sore so close to our shore. Dr. Miguel Faria gives us a rare eyewitness look at the personal costs of Castro's heinous takeover of Cuba."—PHYLLIS SCHLAFLY, EAGLE FORUM

"Dr. Miguel Faria has shown two things that strike me as essential for Americans to understand. One, gun registration was the tool for Castro to disarm the people of Cuba prior to committing genocide. Two, be careful lest we get what we say we want. The people of Cuba wanted to get rid of the dictator Batista. They did, and then got Castro. I hope that Americans will be more careful about who they support for making needed changes in our government."—LARRY PRATT, EXECUTIVE DIRECTOR, GUN OWNERS OF AMERICA



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"An impassioned plea for freedom...!"—BRIGID MCMENAMIN, *FORBES* MAGAZINE

Miguel A. Faria, Jr., M.D.
Editor-in-Chief of the *Medical Sentinel* of the Association of American Physicians and Surgeons (AAPS) and author of *Vandals at the Gates of Medicine* (1995) and *Medical Warrior: Fighting Corporate Socialized Medicine* (1997).

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Other People's Money

BY DEVON HERRICK

On Capitol Hill, members of Congress are continually increasing the price Americans pay for health care. They do this by giving away benefits and, in some instances, by making people buy unwanted benefits. Mental health parity, a patients' bill of rights, a prescription drug benefit tacked onto Medicare—the expenses are endless.

One would expect taxpayers to be outraged, but they're not. For the most part, Americans care little about the rising cost of health care ... because they think they don't pay for it. Most Americans think health care should be paid for with "other people's money."

No Such Thing as Free

There's also no mystery why 39 million people lack health insurance. Coverage mandates—for everything from fertility treatments to baldness treatments—have driven up premium prices beyond the reach of many Americans. Those debating whether they can afford insurance quite often decide to forgo it, knowing they can still obtain care without it.

"People tend to spend a lot more, expect a lot more, and care very little about prices, when health care is paid for with other people's money."

For instance, many low-income children (and some adults) are eligible for government-subsidized insurance through Medicaid. Many who are eligible for this subsidized health insurance don't bother applying. In the event of a major illness, they can obtain completely free medical care if needed. Hospitals are forbidden by law from turning away patients in need of emergency care for which they are unwilling or unable to pay.

Of course, these services are not actually free: Someone has to pay for them. They are paid with other people's money.

Even Employers Don't Pay

The poor are not the only ones seeking health care paid with other people's money. Many happily employed people think their employer should pay for employee health insurance. Some politicians have even suggested a law requiring it.

Of course, when all is said and done employers do not pay for health insurance: their employees pay for it. If an employer is required by law to provide health insurance coverage, he'll simply offer his employees less in cash wages, or he'll hire fewer people. Employers have a personnel budget: increase the costs in one part of that budget, and other parts will be cut back.

A young woman complained to me that her husband's employer-sponsored health insurance lacked family coverage. Since they were ready to start a family, she needed an individual health insurance policy with maternity coverage. Maternity benefits raised the price of her insurance policy to about $1,000 per month.

There ought to be a law, she thought, requiring insurance companies to sell individual policies (with $12,000 in maternity benefits) to any couple willing to pay $2,000 in premiums. In other words, she wasn't willing to pay the price for having a baby: She wanted that paid with other people's money.

Senior Rights

Our greed only gets worse as we get older.

Although senior citizens, as a group, are the wealthiest population in the U.S., they receive generous government-subsidized medical benefits. The *Economist* reported today's seniors could expect to receive $2.50 in benefits for every dollar they paid into Medicare ... and that's under today's set of benefits. Both houses of Congress are currently trying to add a prescription drug benefit to Medicare—even though two-thirds of senior citizens already have drug coverage.

A recent poll by National Public Radio, Kaiser Family Foundation, and Harvard's Kennedy School of Government confirms the "other people's money" attitude. The poll asked seniors what proportion of their annual prescription drug expenditures insurance should pay. Almost half said at least 50 percent, and 41 percent thought insurance should cover substantially more than that.

When asked how much they would be willing to pay out-of-pocket toward such a benefit, 69 percent said only $30 a month or less. Ten percent were willing to spend $30, 14 percent were willing to spend $20, and 15 percent were willing to spend just $10. Nearly one-third (30 percent) of the senior citizens polled were not willing to contribute *anything* toward helping themselves and their fellow seniors obtain affordable Medicare drug coverage. They wanted expensive drug coverage paid for with other people's money.

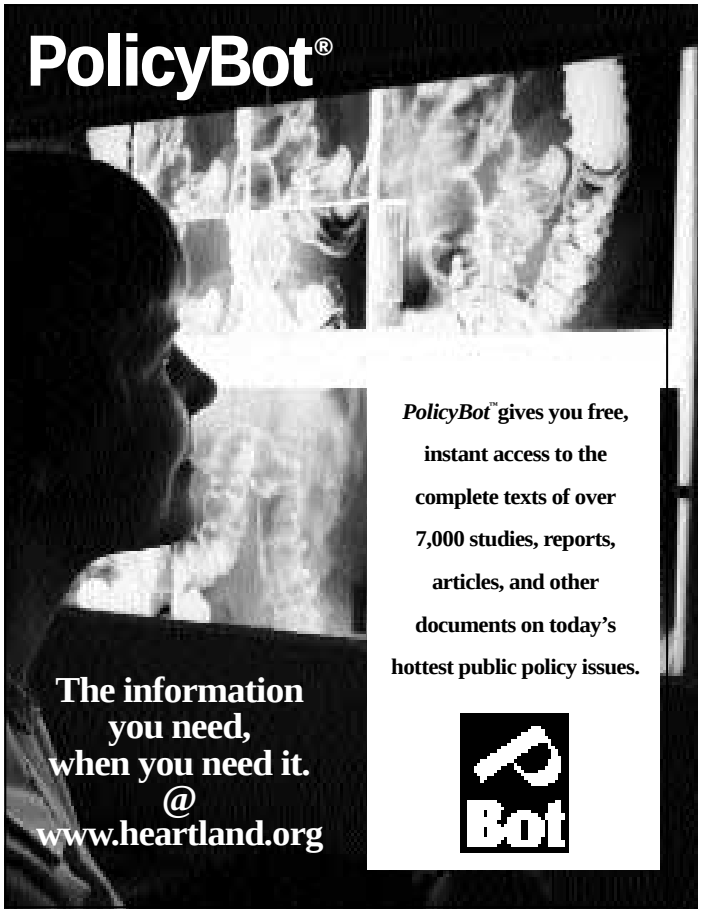
For more information…

WWW on NCPA and its health policy work, visit the group's Web site at **http://www.ncpa.org**.

When those same senior citizens were asked, in the same survey, what would be a reasonable amount to pay for a prescription drug benefit, only 16 percent thought it reasonable to expect that benefit for free—although 30 percent had said they weren't willing to pay anything. That's an awful lot of people admitting they're being unreasonable!

Sadly, the same survey found few adults understand what health economists have long known: A large portion of the rise in health care costs is explained by demand. People tend to spend a lot more, expect a lot more, and care very little about prices, when health care is paid for with other people's money.

Devon Herrick is research manager at the National Center for Policy Analysis, Dallas, Texas.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POOLS continued from page 1

dard underwritten health insurance policy, must give consumers a choice between two or more plans, and must have a mechanism for continued funding that does not rely on federal subsidies. States that already have HIPs generally charge a capped premium and assess health insurance companies a "surcharge" to help cover claims.

Consumers Win

Kelly Loussedes, director of public relations at the National Association of Health Underwriters (NAHU), reacted positively to news of the HIP measure. "High-risk pools have provided affordable health care choices for thousands of individuals who would otherwise be uninsured. We are hopeful the additional federal funding will encourage other states to implement them."

Kerry Smith, director of government relations for Fortis Health, agreed. "As an alternative to the costly and detrimental effects of mandated guaranteed issue, risk pools provide a viable safety-net for individuals with chronic or high-risk medical conditions. As I have told many members of Congress and the White House, these people need coverage, and risk pools are there for them ... just give them the money."

"HIPs accomplish the social goal of assuring access to quality medical care for those who need it," noted Joseph Bast, president of The Heartland Institute, "without the disruptions and negative side effects caused by heavy-handed regulations of the insurance industry."

"Ensuring all Americans have access to affordable health insurance is one of the most important issues facing Congress," commented Dr. Merrill Matthews, director of the Council for Affordable Health Insurance (CAHI). "As the nation continues to debate the best way to ensure access to affordable coverage, high-risk pools must be a part of the solution."

Matthews told *Health Care News* that House-Senate conferees came together to draft a bill that is good for the economy and increases access to affordable health insurance for many Americans. The conferees removed a guaranteed issue provision, he noted.

Keeping What You Have

The appearance of health care reform measures in a trade bill isn't entirely surprising.

"The trade bill also helps eligible individuals maintain their health insurance if they lose their jobs due to trade arrangements," explains Janet Trautwein, vice president of government affairs at NAHU.

"There are more than 39 million Americans who are currently uninsured, and this legislation will ensure that those numbers do not rise," Trautwein noted. "Displaced" individuals who qualify under the legislation would receive a refundable tax credit in advance to purchase health insurance from a number of different sources, including COBRA, purchasing pools, high-risk pools (HIPs), and other state assistance programs.

Rick Carlson, director of Illinois' high-risk pool, the Comprehensive Health Insurance Pool (CHIP), said "[TAAA] appears it could be as significant and beneficial for consumers as the federal HIPAA that was first enacted in 1996. In the past year there have been a number of steel mills and other Illinois employers who have declared bankruptcy and gone out of business who have left literally thousands of employees, retirees ,and their dependents without health insurance."

Carlson told *Health Care News*, "Our CHIP program has been able to enroll and help hundreds of these individuals, but many more were unable to qualify or enroll, either because of their having failed to exhaust all of the COBRA coverage that was available to them or because they were unable to afford this coverage (having lost their job and source of income)."

"This legislation," said Carlson, referring to the trade measure, "should be of great benefit to these displaced workers, who can now receive financial assistance to continue their previous coverage and/or access other available coverage options such as their state's high-risk pool."

"Significant health care reform legislation is buried deep in [the Trade Adjustment Assistance Act], its presence mostly ignored by the mainstream media."

What Are High-Risk Pools?

People who typically seek coverage in a high-risk pool are those who have been turned down for coverage due to a chronic illness or condition; those who have found they can access only restricted coverage due to their health; or those who have insurance that has been premium rated higher than what might be available from a risk pool.

High-risk pools play an important role in a free-market health care system. They are state-chartered, nonprofit associations offering comprehensive health insurance through the private sector to individuals with pre-existing and chronic health problems.

People who typically seek coverage in a high-risk pool are those who have been turned down for coverage due to a chronic illness or condition; those who have found they can access only restricted coverage due to their health; or those who have insurance that has been premium rated higher than what might be available from a risk pool.

Risk-pool insurance typically costs more than standard coverage. Premiums are capped by law and range from 125 percent to 200 percent of the premiums charged for standard coverage. Under the provisions established by TAAA, a state must cap the premium at 150 percent of standard in order to qualify for federal funding.

It is inherent in the design of a risk pool that it will lose money. It simply isn't feasible to pool a group of individuals known to have major health problems and expect their premium contributions to cover the entire cost of their care. For this reason, risk pools need some form of subsidy, often an assessment charged to insurance carriers in the state.

Risk pools are overseen by an appointed board of directors, usually including representatives from the insurance industry, consumers, and medical professionals. The pools are often supervised by the state's insurance department. A private third-party administrator typically handles day-to-day claims and administrative operations.

"[High-risk] pools give the insurance industry and the general public a way to share and spread out the costs of insuring medically risky people on a broad and predictable basis."

Overall enrollment in risk pools is rising. Today, approximately 130,000 people are enrolled in 30 state pools. Some of the enrollment increase can be attributed to the Health Insurance Portability and Accountability Act (HIPAA), passed in 1996, which allowed states to choose their risk pools as a mechanism to provide portability guarantees for people leaving qualified group coverage for the individual health insurance market.

"Today, approximately 130,000 people are enrolled in 30 state pools."

Stabilizing the Free Market

Risk pools are an important mechanism for providing stability in a state's individual health insurance market. A pool provides a place where high-risk individuals can gain comprehensive coverage and protection against premiums climbing too high. The high-risk policy-holder is moved from the standard rating pool and placed in one designed to accommodate special and expensive care not needed by most of the insured population.

Pools give the insurance industry and the general public a way to share and spread out the costs of insuring medically risky people on a broad and predictable basis.

Studies of the individual insurance market have found states with risk pools have had more success in keeping their individual health insurance markets competitive, keeping insurance rates affordable, reducing Medicaid enrollments, and increasing private coverage.

The District of Columbia and 19 states are currently without high-risk pools. Those states are: Arizona, Delaware, Georgia, Hawaii, Idaho, Maine, Maryland, Massachusetts, Michigan, Nevada, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Dakota, Vermont, and Virginia.

For more information…

WWW see *Heartland Policy Study* #91, "Extending Affordable Health Insurance to the Uninsurable," by Conrad F. Meier. The report is available on the Internet at **http://www.heartland.org/studies/meier-ps.htm**, or in Adobe Acrobat's PDF format at **http://www.heartland.org/studies/meier-ps.pdf**.

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Micro-Management Failed Us in Vietnam ... Is Medicine Next?

BY DRS. MICHAEL ARNOLD GLUECK AND ROBERT J. CIHAK

For 35 years, Ron Glasser has pursued two passions. The Minneapolis physician has enjoyed a distinguished career as a pediatric nephrologist, or kidney specialist. And he has authored six books, including two *New York Times* bestsellers. He's even been nominated for the Pulitzer Prize.

But his most important book may be the one no publisher will touch: the book that demonstrates a connection between the kinds of thinking that lost the Vietnam War, and the rise and imminent collapse of "managed care" and the whole HMO system.

First, a little history; then the HMO/Vietnam nexus; then some final thoughts.

After World War II, medicine was getting better and better, and more people wanted more and more of it. Unfortunately, modern medicine is inherently expensive: it's high-tech, and it has to be performed by highly trained practitioners, one patient at a time.

After 1963, cost escalation in health care became a way of life. Medicare and Medicaid made health care essentially free at the point of service for the elderly and the poor—the two groups that use it most heavily in America. By the 1970s, escalating insurance premiums helped destroy American competitiveness. Government, business, and the insurance companies were looking for a way out.

"Like Lyndon Johnson, Richard Nixon, and the Pentagon [after Vietnam], the managed care industry now finds itself in the midst of a full-fledged backlash."

Enter Managed Care

The HMO Act of 1973, ugly progeny of Richard Nixon and Edward Kennedy, became law because it offered—or seemed to offer—something for everyone.

Managed care, the brainchild of a non-practicing Minneapolis physician, Paul Ellwood, promised to wring the waste out of the system by encouraging people to stay healthy, offering insurance coverage for routine services, and setting objective standards for providers of other forms of care. Best of all, HMOs would achieve their miracles by "competing in the market" for business.

That they would be competing for large corporate and government insurance contracts, not patients, seemed unimportant at the time. So did the fact that "wringing out the waste" was a one-time affair. Once HMOs had offered cheap contracts that pledged them to provide all necessary services, they might reach a point where the only way they could make money would be to ration and deny care.

Along came Alain Enthoven, one of the chief systems analysts in Robert McNamara's Pentagon. After spending seven years applying cost-benefit analysis and advanced micro-management techniques to everything from nuclear weapons to the Vietnam War, "Whiz Kid" Enthoven left the Pentagon for a brief stint in the private sector.

"Alain Enthoven ... devoted ... three decades trying to make managed care succeed by applying techniques that had failed so miserably in Vietnam."

He soon landed at Stanford University, where he devoted the next three decades trying to make managed care succeed by applying techniques that had failed so miserably in Vietnam:

- Centralized micro-management by a self-anointed executive command team who felt they knew more about the war against disease than the physicians who had to wage it.
- Reduction of medical problems to statistical problems—i.e., the notorious "body-count" mentality applied to the rationing of medical care.
- Endless second-guessing of practicing doctors to the point that, if a physician's diagnosis or recommendations deviate from the computer's, the *physician* must spend hours justifying his decisions, usually to some clerk at the other end of an 800 number.

Too Hot to Handle

Ron Glasser's book, titled "Care Denied," has found no takers, despite his proven skill as an author and despite the timeliness of the issue. Glasser's work helps explain why President George W. Bush and Senator Kennedy are stumping for a "patient's bill of rights" aimed at rectifying problems caused by government intervention—the result of 1973's unholy alliance between Nixon and Kennedy himself.

Glasser now wonders whether it may be too late to alert people to the Vietnam connection, if only because the strategic geniuses of the HMO industry have moved on to another model: Enron.

"The Vietnam connection," Glasser says, "is old history. We've moved beyond all those pompous pronouncements to a system where today premiums are going up 15 to 20 percent a year while services are being cut back; and those hospitals left standing are increasing rates 20 percent every chance they get. The only possible interest of those Vietnam economists who set all this up, is the same interest people are having today who taught all those business school graduates at Enron and Andersen how to lie, steal, and screw everyone but themselves."

That interest, we suspect, is just this: Proving that nothing was ever their fault.

Like Lyndon Johnson, Richard Nixon, and the Pentagon, the managed care industry now finds itself in the midst of a full-fledged backlash. HMOs today are in full retreat, but they're still there, and they want to make some more money before the feds or employers put them out of business.

Unlike five years ago, today they know the system is dying. They're just scrambling to keep it alive a little longer so they can extract another year's sickening salary and bloated bonus.

Some tactics just don't work in war, business, or medicine. Patients will have no confidence or peace of mind until managed care either dies or is humanely euthanized.

Michael Arnold Glueck, M.D. writes on health issues and Robert J. Cihak, M.D. is the immediate past president of the Association of American Physicians and Surgeons. Collaborating as The Medicine Men, they write a weekly column for WorldNetDaily.

Looking for an outstanding speaker?

Who is Dr. Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

Engagements are scheduled on a "first come, first served" basis, so call 312/377-4000 today to schedule Dr. Merrill Matthews to keynote your next event!

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State Legislative UPDATE

COMPILED AND EDITED BY CONRAD F. MEIER

Managing Editor's note: Information here on legislative activity regarding MEHPA was provided by Andrew Schlafly, Esq., general counsel for the Association of American Physicians and Surgeons (AAPS). He can be reached at 908/719-8608.

ARIZONA

Under the Model Emergency Health Powers Act (MEHPA) legislation passed this session, Arizona's governor may declare an emergency only if there is a substantial risk of a significant number of human fatalities or permanent or long-term disability. The governor may quarantine only if it is the least-restrictive means available to address the risk. The governor's quarantine power expressly includes the possibility of detention in one's residence.

FLORIDA

According to MEHPA law, the Florida public health department or the governor may declare a health emergency based on an incident resulting in substantial risk of harm to public health. The health department has the power to use law enforcement to forcibly quarantine or by "any means necessary" vaccinate residents. No exceptions are recognized in the measure.

GEORGIA

Under new MEHPA rules, Georgia's governor must call a special session of the legislature to approve or reject a declaration of a public health emergency, which requires a "high probability" of harm to a "large number" of people.

The vaccination rules must permit "consideration of the opinion of a person's personal physician as to whether the vaccination is medically appropriate or advisable for such person." Unless there is "an epidemic or immediate threat thereof, the vaccination requirement shall not apply to any person who objects in writing thereto on grounds that such immunization conflicts with his religious beliefs."

MAINE

Maine's MEHPA will sunset in 2003. The health department must prove by clear and convincing evidence at a hearing, within 48 hours of detaining someone, the "person has been exposed to or is at significant medical risk of transmitting a communicable disease that poses a serious imminent risk to public health or safety and there are no less restrictive alternatives available to protect the public health and safety." The court must rule within 24 hours of the hearing to release the person or detain him for a period no longer than 30 days.

MARYLAND

Using provisions in the new state MEHPA, Maryland's governor may declare a "catastrophic health emergency," limited to an imminent threat of extensive loss of life or of serious disability caused by exposure to a deadly agent, which is explicitly defined in the measure. Among the deadly agents identified are Anthrax, Ebola, plague, Smallpox, mustard or nerve gas, or deadly radiation.

MINNESOTA

Under rules established in MEHPA, the Minnesota commissioner of health must apply for a court order within 24 hours after detaining someone, and must then release the detainee if a court order is not received within 48 hours. The sun sets on MEHPA in 2004.

NEBRASKA

On July 23, Nebraska Governor Mike Johanns (R) said he plans to cut approximately $20 million from the state budget by eliminating what he called "loopholes" in the state's Medicaid eligibility requirements. The state expects income from taxes to be $255 million less than the $5.2 billion projected earlier in the current two-year budget cycle.

Under a plan expected to save $11.7 million this fiscal year, which ends June 30, 2003, and $17.6 million during a 12-month period, Johanns has proposed to end a mathematical formula called "stacking," which the state uses to determine Medicaid eligibility. Through stacking, the state breaks families into smaller units and assigns each unit a portion of the family's annual income. The practice allows some middle-income families, who otherwise would have incomes too high to qualify for Medicaid, to receive benefits.

Johanns also would reduce the amount of income the state disregards when determining eligibility, a move expected to save $2.7 million this fiscal year and $4 million over a 12-month period. His proposal also would freeze payment levels to Medicaid providers to save the state about $7 million per year and would begin to alter some payment rules for hospitals and pharmacies.

NEVADA

At least one orthopedic surgeon has agreed to return to work at the trauma center at Las Vegas-based University Medical Center, and several others are reconsidering their resignations following a decision by the state attorney general to temporarily cap legal damages in malpractice cases at $50,000 if physicians return to the center.

The only trauma center serving southern Nevada closed July 3 after all but one of its 58 orthopedic surgeons quit, citing escalating medical malpractice insurance premiums.

The cap, issued by the state attorney general on July 9, will be in effect for 45 days until the state legislature can address tort reform. Governor Kenny Guinn (R) has said he will call a special legislative session.

Orthopedic surgeon Dr. Michael Daubs, president of the Nevada Orthopedic Society, said he is "willing to go back to work" and is "comfortable that [he] will be protected under the cap." Daubs said he has been encouraging other doctors to return as well.

NEW HAMPSHIRE

MEHPA gives New Hampshire's governor the power to declare an emergency, which the legislature may revoke. The initial period of emergency is only 21 days; a court order is required to quarantine.

SOUTH DAKOTA

South Dakota is one state where the Senate impasse over prescription drug legislation has become an important issue.

In a hotly contested U.S. Senate race, Rep. John Thune (R) has said incumbent Sen. Tim Johnson (D) "offers no real solution" to the problem of increased prescription drug costs. "Johnson has spent an enormous amount of his congressional career talking about prescription drugs, but he has never voted for a bill that's passed."

The issue is thought to be critical since many seniors reside in rural areas and cannot afford to purchase prescription drugs. The Senate began debate on prescription drug legislation, including two Medicare prescription drug benefit bills, in late July. In June, the House passed a Republican-sponsored bill (HR 4954), which Thune supports. The bill would allow Medicare beneficiaries to purchase prescription drug coverage directly from private insurance companies. The Senate bill did not pass the Democrat-controlled Senate.

WEST VIRGINIA

Officials are working to address a $187 million budget deficit in West Virginia's Medicaid program for this fiscal year. The program faces a $47 million loss because of an increase in beneficiaries and costs and a decrease in revenues. It risks losing $140 million in federal matching funds.

To help trim Medicaid costs, the state Department of Health and Human Resources is working to negotiate discounts with drug companies under a law approved by the state legislature earlier this year. The law also allows the state to establish a "preferred drug list," which would offer doctors incentives to prescribe Medicaid beneficiaries lower-cost medications on the list.

The State Legislative Update is compiled from a wide range of news sources, including the Council for Affordable Health (CAHI) http://www.cahi.org; *the National Association of Health Underwriters (NAHU)* http://nahu.org; *Bizjournals* http://bizjournals.com; *Stateline* http://stateline.org; *and Lexis/Nexis research.*

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The Galen REPORT

A monthly review of health policy matters

The country dodged a bullet when the Senate rejected the latest compromise bill for a Medicare prescription drug benefit. The final bill was one of the worst the Senate considered—a plan that would have threatened health care and even Medicare's very existence.

It was the last of four major Medicare prescription drug bills the Senate rejected during nearly two weeks of debate. The final proposal, sponsored by Democrat Bob Graham of Florida and Republican Gordon Smith of Oregon, offered a government-run drug benefit for people with incomes under 200 percent of poverty ($17,720 a year for an individual and $23,880 for a couple).

Medicare already requires increasing amounts of taxpayer money to meet its obligations. Adding this $400 billion new entitlement without any reform of the Medicare program would put even more strain on a program that millions of baby boomers are counting on when they retire. Worse, it would accelerate Medicare's bankruptcy.

This Senate bill was only a beginning. Sen. Ted Kennedy of Massachusetts said the Graham-Smith compromise was "an important down payment on the kind of program senior citizens need and deserve."

Unfortunately for seniors, an earlier version of Graham's bill signaled what kind of a program that down payment would buy.

It would have limited the number of drugs available to two per "therapeutic class." That means the government would have picked two preferred drugs for ulcers, two for arthritis, two for hypertension, and so forth. Other drugs that millions of seniors want and need would not have been on the list.

Pharmaceutical companies would be reluctant to gamble the $800 million it costs them to develop a new drug for fear they wouldn't get on the government's list. This would crimp the pipeline for new drugs to cure cancer, diabetes, Alzheimer's, and other killer diseases.

Most observers believe the prescription drug issue is dead for this session of Congress. But if senators facing reelection this fall get enough heat when they are home for the August recess, they may pressure Majority Leader Tom Daschle to revive the issue.

If they start the debate again, they would be well-advised to consider a plan that would build on what they learned during their pre-recess debate.

For example, Democrats agreed, for the first time, that Medicare could target more help to lower-income seniors, rather than giving a little something to everyone.

They could try a fresh new approach that provides assistance for lower-income seniors and good catastrophic coverage—which Democrats want—in a privately managed benefit that engages market competition—which Republicans believe is essential.

— Grace-Marie Turner
and Joseph R. Antos

RECENT PUBLICATIONS

The Medicare Drug Benefit War

Tom Miller
Fox News, 07/17/02

The Cato Institute's Tom Miller says the Senate's Medicare prescription drug benefit legislation "sets the stage for a new runaway entitlement program, unsustainable stress on an already-shaky Medicare program, and serious threats to future medical progress."

Miller says the proposals should focus on expanding private competitive insurance choices to provide affordable prescription drug coverage within integrated benefits packages. Congress also should encourage higher deductibles and catastrophic loss protection, targeted assistance to lower-income seniors, reformed individual Medigap coverage, and a deregulated Medicare+Choice program. Miller warns ineffective legislation will result in "waves of drug coverage rollbacks, regulatory restrictions, tighter drug formularies, and price controls ..."

Full text: http://www.foxnews.com/story/0,2933,57985,00.html

Crafting a Health Care Tax Credit in the Trade Bill

Nina Owcharenko
The Heritage Foundation, 07/16/02

"With House and Senate adoption of tax credits as part of the Trade Adjustment Assistance (TAA) program, Members have a unique opportunity to implement effective health care policy," says Nina Owcharenko of The Heritage Foundation. Members should work in the conference committee to allow tax credit recipients to apply the credit to the plan of their choice, including policies purchased in the individual market, private options offered through the state, and coverage previously provided by a former employer.

Full text: http://www.heritage.org/library/execmemo/em824.html

Our Own Worst Enemies: Explaining Premium Increases in the Individual Health Insurance Market

Mark Litow, F.S.A.
Council for Affordable Health Insurance, 07/02

Employers, consumers, and legislators are responsible for the rising cost of health insurance, says Mark Litow, an actuary for Milliman USA.

He attributes premium increases of as much as 225 percent to four key factors:

1) cost shifting, which has increased the cost of premiums between 15 and 50 percent;
2) mandated benefits, which encourage people to increase their utilization beyond what they might otherwise use;
3) underwriting and rating restrictions, such as guaranteed issue and community rating; and
4) comprehensive benefit packages that result in high utilization and little focus on costs.

"The upward trend could be moderated or even reversed if consumers, employers, and legislators embraced lower-cost basic coverage or high-deductible policies and stopped trying to micromanage the system," concludes Litow.

Full text (pdf): http://www.cahi.org/Issues&Answers/IndMarketPremIncreasesPDF.pdf

English Health Care: Not Your Cup of Tea

Conrad F. Meier
Health Care News, 05/02

Evidence shows Britain's National Health Service (NHS) "is plagued by political bureaucracy, endless delay, low-quality care, and poor medical outcomes," says Conrad Meier of The Heartland Institute. Meier traveled to England to study the NHS first-hand and wrote about his experiences in a four-part series. The series offers an overview of the NHS, explains how British policy experts wish to add greater freedom of choice to their health care system, examines efforts to fix the NHS, and provides some of his own conclusions.

Full text: http://www.heartland.org/health/may02/tea4.htm

Attack of the (Medicine) Clones

Anthony E. Daniels
The Washington Times, 7/16/02

An FBI agent of 27 years, Anthony Daniels believes re-importing prescription drugs from other countries would be a mistake.

"Legislation allowing re-importation of U.S.-made drugs from abroad could open the floodgates to adulterated and often dangerous counterfeit drugs from unscrupulous profiteers, deranged individuals, and even terrorists," said Daniels. "I am aware of operations in which counterfeit prescription drugs were seized. Some of the drugs confiscated were formulated to come close to the genuine prescription of the American-made ones they copied, but few were exact copies. It's likely they were not manufactured under squeaky-clean sterile conditions."

Full text: http://www.washingtontimes.com/op-ed/20020716-70606946.htm

Premium Pain Relief

Thomas J. Bray
The Wall Street Journal, 7/23/02

Columnist Thomas Bray and his wife recently made a trip to a Costco in Windsor, Ontario and made some surprising discoveries about Canadian drug prices.

Over-the-counter drugs such as aspirin are up to 30 percent more expensive in Canada than in the United States. Government price controls on patented drugs have caused companies to make up profits by raising the prices on generic and over-the-counter drugs.

Bray also argues patented drug prices in Canada are cheaper partly because legal costs are lower due to more restrictive liability law.

Full text: http://www.opinionjournal.com/columnists/tbray/?id=110002025

Cutting Taxes for Insuring: Options and Effects of Tax Credits for Health Insurance

Mark V. Pauly and Bradley Herring
The AEI Press

Tax credits for health insurance do not have to provide a full subsidy to be effective in helping low-income workers, find Mark Pauly of The Wharton School and Bradley Herring of Yale University.

Pauly and Herring examine the impact of specific tax credit options on the uninsured and find a modest credit paying 50 percent of the premium would reduce the number of uninsured workers and family members with low incomes by as much at 52 percent. The authors also find most high-income workers would keep their group coverage even if offered a modest credit for individual health insurance.

Full text (pdf): http://www.aei.org/shop1/shops/1/7160-0.pdf

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, http://www.galen.org. *Grace-Marie Turner is president. This report was produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of* Health Care News.

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My TURN

BY CONRAD MEIER - MANAGING EDITOR

Reform the FDA, Not Patent Laws

The Senate's recent passage of the Greater Access to Affordable Pharmaceuticals Act (GAAP) proves Senators are seeking an easy way around a complex issue. While attempting to bring drugs to the consumer market faster and cheaper, the Senate ignores the root cause of the expense and delay: the Food and Drug Administration (FDA).

The GAAP measure would reformulate the 1984 Hatch-Waxman Act by further limiting the intellectual property rights of pharmaceutical companies in order to increase the availability of generic drugs.

But, like all previous government attempts at market manipulation, studies indicate GAAP-style legislation could result in thwarted research and development of drug treatments, which would lead to *fewer*, higher-priced drugs—not more, or more affordable, drugs.

Instead of attacking patent rights, efficiently described in Hatch-Waxman and specifically protected in Article 1, Section 8 our Constitution, legislators should be looking to reform the snail-paced drug approval process at the FDA.

On average, a new drug takes 14 years to move from the research stage to the medicine cabinet. That process costs about $800 million—for each drug. Currently, pharmaceutical firms enjoy a period during which they hold exclusive patents—property rights—to their discoveries, a reward extended to all industries, not just drugs.

It is during this time of protection that brand-name pharmaceutical companies attempt to recoup their investment, reward investors, and raise funds to invest in new medicines. Without this patent protection period, innovative pharmaceutical companies would not have the same incentive to continue their research and development of new medicines.

Personal Experience

Like the FDA, I suffer from an aging problem. Over the years, the FDA bureaucracy has become obese. As for me, I have developed osteoarthritis in my knees. Both these conditions are painful, slow you down, and have a negative effect on productivity and the quality of life.

My pain and walking difficulties became such a daily problem that I opted for a set of three shots (referred to by the FDA as a "medical device") directly into the knee. It is a solution administered by an orthopedic surgeon via a syringe and needle (the device). A set of shots costs $500 per knee. Knee replacement, by comparison, can run about $12,000 per knee and requires extensive physical therapy. It takes about a year to full recovery.

For many people, the relief brought by the drugs-into-the-knee approach can last six months or more, and can be repeated if tolerated well the first time around. As in my case, the shots are particularly effective for younger healthy seniors with recuperative powers. Even frail seniors, whose health can be severely compromised by knee replacement surgery, consider drug treatments a miracle.

The drug treatment, but for the long and costly regulatory delay, could have been available to me many years earlier, when the first symptoms of knee pain appeared. Patent protection laws didn't slow down the process of getting that "device" to my knees. The FDA did.

FDA in Slow Motion

After some research, I learned the shots-to-the-knee approach, called Synvisc-Hylan, was developed in the Netherlands by Genzyme Biosurgery. It has been used successfully in Europe since the late 1980s. Had I known about it sooner, I could have had the shots administered years earlier while on a visit to Germany. I only learned of Synvisc-Hylan from a magazine advertisement featuring Hall of Fame golfer Nancy Lopez promoting how she "found knee pain relief."

According to FDA review data detailed in the January 10, 2001 *Federal Register* (Vol. 66, Number 7), Genzyme Biosurgery and Wyeth Pharmaceuticals partnered and applied for FDA approval of Synvisc-Hylan in 1989. The approach was finally approved for use in August 1997, eight years later.

When reviewing the Synvisc-Hylan application, the FDA did not consider relevant the data from the European clinical trials of the approach. If it had, the approval process in the U.S. could have moved much more quickly.

Dr. Henry I. Miller, former FDA official and author of *To America's Health: A Proposal to Reform the Food and Drug Administration*, writes, "Although few Americans are aware of it, most of the process of drug development has always been conducted by the private sector. Industry, not the FDA, performs the discovery and clinical testing of new drugs under FDA rules."

Miller thinks the FDA evaluation process differs from its counterparts abroad in that other countries rely much more heavily on experts from the private sector, rather than a bureaucratic government agency. The approval process in the United Kingdom and European Union is thought to be more efficient than the process here in the U.S. Those countries regularly perform reviews as or more rapidly than we do here ... with significantly less staff and expense.

Sheila Shulman, Peg Hewitt, and Michael Manocchia point out in their article, "Studies and Inquiries into the FDA Regulatory Process: An Historical Review," published in the April-June 1995 of the *Drug Information Journal* (Vol. 29, No. 2), "Numerous independent analyses, including comparison of the FDA with drug regulators abroad, have produced recommendations for improvements that would reduce the time, the cost, complexity, and unpredictability of the research and development process."

According to Miller, none of the recommendations reviewed by Shulman and her coauthors came close to reforming the FDA. "Even," writes Miller, "the much-touted Food and Drug Modernization Act of 1997 did little more than codify what was already in place."

Lessons for Legislators

Until now, I admit, I had little appreciation for the convoluted, time-consuming, and expensive process of drug invention-to-approval. You pay more attention when it's your own health on the line.

The slow pace of the FDA put my health at risk. And Genzyme Biosurgery lost eight years of patent protection and millions of dollars in a costly delay, all of which is now reflected in the cost of their medication.

Don't misunderstand me. I don't blame politicians for the pain and discomfort from my failing knees. They got banged up pretty good while I was coaching youth hockey in Chicagoland.

But I do hold those politicians responsible for failing to reform the FDA while at the same time giving me a snow job about how patent laws are the problem. If anyone needs an example of good politics and lousy social policy, this is it!

What do you think? Write me at meier@heartland.org.

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